



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Mehta, Ankur

Respondent Name

Travelers Indemnity Company

MFDR Tracking Number

M4-14-1647-01

Carrier's Austin Representative Box

Box Number: 5

MFDR Date Received

February 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that the CPT codes and MAR are not bundled nor compounded and are to be billed and reimbursed separately and independently from one another. As you will note from the attached supporting documentation all components were performed and billed accordingly based on the TDI-DWC Fee Guidelines and per Rule 133. Please note that Designated Doctor Referred Diagnostic Testing is not subject to PPO or network reductions."

Amount in Dispute: \$1,345.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution should be dismissed under Rule 133.307(f)(3)(D) as the Provider failed to timely submit the Request to the Division in accordance with Rule 133.307(c)(1). As there was no dispute as to compensability, extent of injury, or medical necessity, the Provider was required to file the Request for Medical Fee Dispute Resolution within one year of the date of service. Based on the date of service in dispute of 7-23-2012, the Request for Medical Fee Dispute Resolution was required to be filed with the Division no later than 07-23-2013. As noted by the Division's received date stamp on the DWC-60, the Request was received on 02-07-2014, or 199 days late. As such, this Request for Medical Fee Dispute Resolution should be dismissed for failure to comply with Rule 133.307."

Response Submitted by: Travelers Indemnity Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
7/23/2012 - 7/23/2012	EMG/NCV	\$1,345.31	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is 7/23/2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on 2/7/2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April , 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.